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## BACKGROUND

A Pregnancy confined to the ovary accounts for upto 3% of all ectopic pregnancy and is the most common type of non tubal ectopic pregnancy. Unruptured ovarian ectopic is Rare and is Diagnosed if four clinical criteria are fulfilled outlined by Spiegelberg:

1. Ipsilateral tube is intact and distinct from the ovary.
2. Ectopic pregnancy occupies the ovary.
3. Ectopic pregnancy is connected by the uteroovarian ligament to the uterus.
4. Ovarian tissue can be demonstrated histologically amid placental tissue.

11 per 1000 pregnancies are ectopic out which 95% are tubal and 5% are Non tubal.

Non tubal ectopic pregnancy is very rare but potentially Life threatening and often misdiagnosed and can have a rare presentations.



Figure 1: Intact Gestation sac

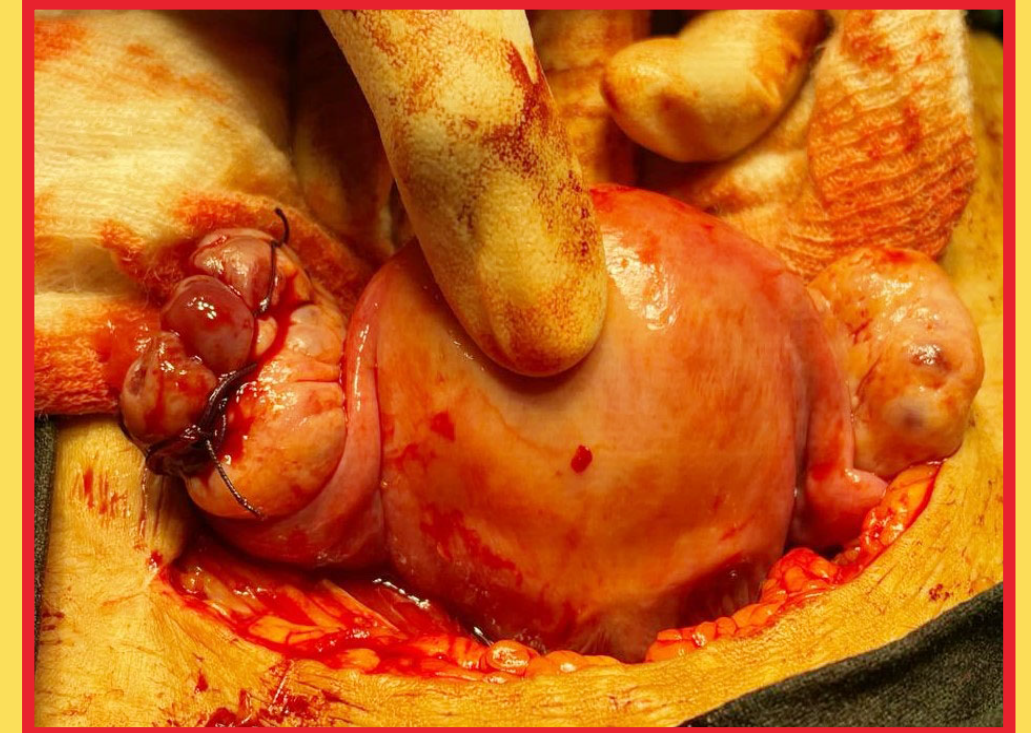


Figure 2: In process of expulsion



Figure 3: Haemostatic suture seen with ovarian ligament

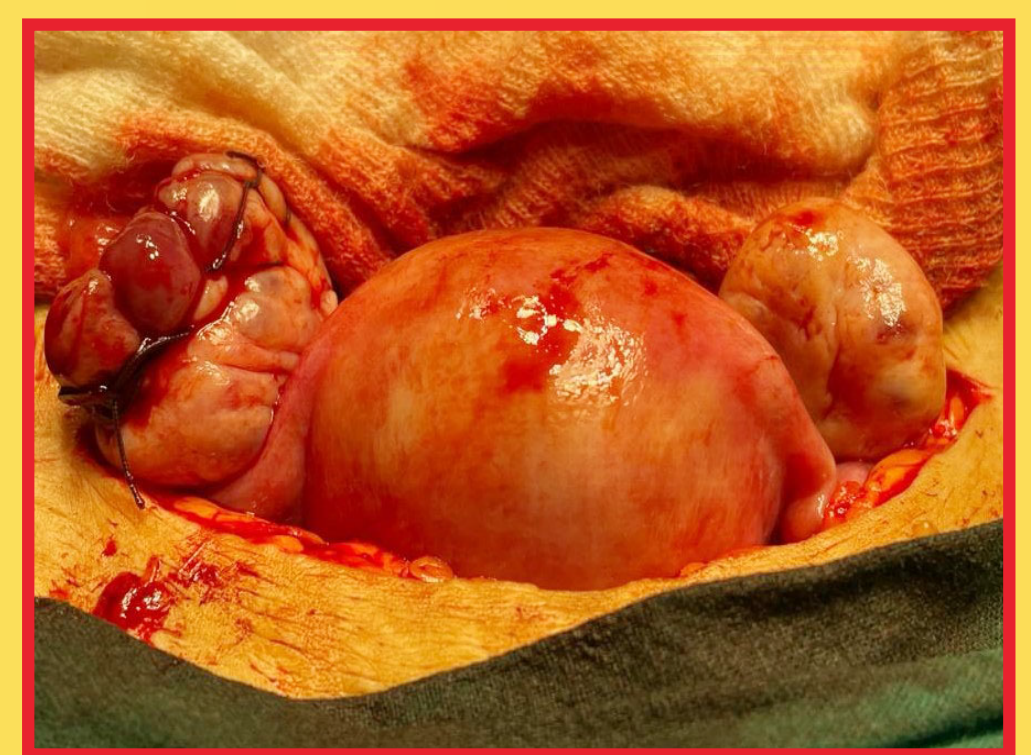


Figure 4: Intach b/l tubes and uterus

## CASE REPORT

A 26yr old female G4P2L1A1 presented in Gynaecology OPD with H/O Intake of unsupervised MTP pills 5 months back for 6 weeks of pregnancy Followed by suction and evacuation for excess of bleeding 5months back.

- C/O Chronic dull aching pain in lower abdomen on and off since 5 months. Occasionally pain would radiate to the right shoulder since last one month.
- No H/O syncopal attack .

On Admission patient was clinically and haemodynamically stable.

Per Abdomen examination -Tenderness on Right Iliac Region.

Per Vaginal examination - Uterus Anteverted, soft bulky, Mobile, mass 4\*3cm felt in the right and Posterior fornix tender, cervical movements not tender.

**Investigations:** UPT – Hb-7.9g/dl, Positive, Beta HCG-271.60mIU/ml, CA-125-114.40U/ml.

Ultrasonography – Heterogenous solid cystic mass lesion seen closely adherent to right ovary of size 5.5\*2.8cm showing mild vascularity.

## HOSPITAL COURSE

After taking written & informed consent with blood arrangement, patient taken for Exploratory laparotomy an intact pregnancy sac in the Right ovarian fossa, was in the process of expulsion. Uterus and both tubes were normal and away from the mass. Gestational Sac over the ovary removed gently. Corpus luteum was on right ovary itself with bleeding surface. Haemostatic sutures were applied to the site. Few blood clots of 150 ml were removed from Pouch of Douglas. Received single unit of blood. Post operative period uneventful. Post operative patient was comfortable and stable.

**Histology Pathology** - Chorionic villi within the ovarian stroma suggesting of an ovarian pregnancy.

## CONCLUSIONS

Ovarian pregnancy is a rare variant of ectopic pregnancy and can have rare presentation of Adnexal mass. Early diagnosis of ovarian pregnancy is necessary in order to avoid more serious complications and emergency invasive procedures. However, preoperative diagnosis remains challenging. Its diagnosis is difficult and relies on criteria based on intraoperative findings and histopathology report. Its management remains surgical therapy despite the progress in medical treatment.

High Index of suspicion of ectopic pregnancy should be made in every reproductive age women. Safe abortion practices should be encouraged. Before prescribing any medical abortion confirmation of location of gestation should be done.

## REFERENCES

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